TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
CONSULTANTS IN PAIN MANAGEMENT

**Respondent Name**
TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**
M4-17-1007-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
December 9, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "In review of your explanation of benefits, it seems that you denied our claim for G0479 and G0481 in error... The drug screens are administered to determine patient's compliance with pharmacological pain management plan and/or to determine if non-prescribed medication is being taken by the patient."

**Amount in Dispute:** $333.69

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual claim [claim #] is in the Texas Star Network... Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's name and for its tax identification number, and found no evidence CONSULTANTS IN PAIN MANAGEMENT is a participant in that Network. Further, Texas Mutual has no evidence the requestor, a non-network provider, received out of network approval to provide the service or treatment for date 8/24/16... Because this fee reimbursement dispute involves a Network requirement under the Insurance Code and not the Labor Code, Texas Mutual argues DWC MDR has no jurisdiction in this matter. No payment due."

**Response Submitted by:** Texas Mutual Insurance Company

## *SUMMARY OF DISPUTED SERVICE(S)*

| Date(s) of Service | Disputed Service(s) | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 24, 2016 | G0479 and G0481 | $333.69 | $229.49 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. Texas Insurance Code §1305 applicable to Health Care Certified Networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service
   - CAC-243 – Services not authorized by network/primary care providers
   - 242 – Not treating doctor approved treatment
   - 727 – Provider not approved to treat Texas Star Network claimant

## Issue(s)

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Did the requestor bill in accordance with 28 Texas Administrative Code §134.203 (b)?
3. Is the requestor entitled to reimbursement?

## Findings

1. The requestor billed for HCPC Level II Codes G0479 and G0481 rendered on August 24, 2016 to an injured employee enrolled in the Texas Star Network, a certified healthcare network. The insurance carrier's response indicates that the claim is in the Texas Star Network. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider. The insurance carrier denied/reduced the disputed charges with denial reason code "CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service,"" CAC-243 – Services not authorized by network/primary care provider," "242 – Not treating doctor approved treatment" and "727 – Provider not approved to treat Texas Star Network claimant."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Review of the "Out of Network Authorization to Treat Injured worker Covered by the Texas Star Network", dated April 15, 2016, documents that the requestor Ellen Duncan M.D., obtained an out-of-network approval to treat the in-network injured employee. The out of network referral states in pertinent part, "The request to provide necessary medical services for the above injured worker as an out of network provider has been reviewed and approved. This approval is limited specifically to the provider named above and does not extend to other associates or services within a practice group or business entity. The extent of treatment to be provided as the approved out-of-network provider is limited to the referral consultation and/or services not available within the network."

   Texas Insurance Code §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   The Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so. The Division finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(3). As a result, the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to Texas Insurance Code §1305.153(c).

2. The requestor billed for HCPC Codes G0479 and G0481 rendered on August 24, 2016. For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for the disputed services.

The services in dispute are for clinical laboratory services subject to 28 Texas Administrative Code §134.203 (b) which states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Review of the submitted medical claim finds the health care provider billed for HCPC Codes G0479 and G0481. The Division finds that reimbursement is recommended pursuant to the National Correct Coding Initiative Manual found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, Chapter 12, Section 12.

3. 28 Texas Administrative Code §134.203 (e) states in pertinent part, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

   Reimbursement is determined pursuant to Medicare's 2016 Clinical Laboratory Fee Schedule found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/ and calculated as follows:

   Medicare's Clinical Lab Fee Schedule for HCPCS Code G0479 is $60.60 X 125% = MAR Amount of $75.75.

   Medicare's Clinical Lab Fee Schedule for HCPCS Code G0481 is $122.99 X 125% = MAR Amount of $153.74.

   As a result, the requestor is entitled to reimbursement in the amount of $229.49 for HCPCS Codes G0479 and G0481.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $229.49.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $229.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | January 13, 2017<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.